TREXIN INSIGHT PAPER

June 2, 2021

BREAKING DOWN TRANSPARENCY WITHIN THE CONSOLIDATED APPROPRIATIONS ACT OF 2021

What does it mean for you?

In December of 2020, the Consolidated Appropriations Act 2021 (CAA) was signed into law, which merges COVID-19 stimulus relief with several year-end appropriations bills. These appropriations bills contain numerous stipulations that impact group health plans under the No Surprises Act. These new provisions can be broken down into two easily understandable categories that we will be covering throughout this article: (1) reducing Out-of-Network (OON) costs for enrollees and (2) providing transparency regarding costs.

Even before the pandemic, two-thirds of Americans were worried about being able to afford an unexpected medical bill. In 2020, Georgia, Maine, Michigan, and Virginia passed comprehensive protections, making a total of 17 states with protections against surprise medical billing in both emergency and non-emergency situations. The estimated savings from the No Surprises Act alone is nearly $20 billion over the next 10 years. Many of these provisions are effective in 2022, with some taking effect in 2021, which makes it imperative that plans have full understanding. Trexin Consulting wants to provide a brief outline of important dates and explanations of some main conditions within the CAA.

NO SURPRISES ACT

Starting January 1, 2022 there will be no balance billing for surprise out-of-network (OON) services, including air ambulance transport. The No Surprises Act will protect participants from:

- Unexpected OON emergency care.
- Certain ancillary services provided by OON providers at an in-network facility.
- OON care provided at in-network facilities without patient informed consent.

Additionally, a physical or electronic identification card for Plan coverage (effective January 1, 2022) must disclose in-network and OON deductibles, any Out-of-Pocket Maximum (OOPM) for the Plan coverage, and a phone number and website address where an enrollee may seek assistance. Some other provisions under the No Surprises Act include:

Protections Against Provider Discrimination (effective date unknown)
The CAA requires applicable agencies to propose regulations on a past legislation from The Patient Protection and Affordable Care Act that prohibited discrimination against “any willing provider”.

Advanced Explanation of Benefits (delayed indefintely)
Plans must send participants advanced Explanation of Benefits (EOB) before scheduled care. This must happen three business days before a scheduled service, and no later than one business day after a service is performed. This EOB must include the following information:

- Information regarding whether the provider or facility is in-network.
- An estimate of cost received by the provider or facility based on billing and diagnostic codes.
- The amount the Plan is responsible for paying.

- An estimate of any cost-sharing the enrollee must pay.
- An estimate of the amount an enrollee has incurred toward meeting the limit of financial obligation under the Plan (i.e. deductible and OOPM).
- If needed, a disclaimer that a service is subject to medical management.
- A disclaimer that information is only an estimate and is subject to change.

Continuity of Care (January 1, 2022)
A continuing care patient receiving certain in-network services shall have the right to receive 90 days of continuing care if an in-network care provider leaves the network.

Price Comparison Tool (January 1, 2023/January 1, 2024)
Price comparison must be made available by phone consultation and a website tool so an enrollee is able to compare the amount of cost-sharing that an individual would be responsible for.

Provider Directories (January 1, 2022)

- Plans must ensure in-network directories are up-to-date with access online and over phone.
- Plan must have a process for verifying accuracy of provider information at least every 90 days.
- Have procedure in place for removing provider or facility if Plan is unable to verify information.
- If information regarding provider or facility is requested, Plan must respond in writing within one business day (electronic response if requested by individual)
    - This communication must be maintained in an individual's file for two years.

TRANSPARENCY WITHIN THE CONSOLIDATED APPROPRIATIONS ACT, 2021

In addition to the No Surprises Act, the CAA contained a multitude of other transparency requirements regarding costs and coverage.

Removal of Gag Clauses (effective now)
Plans are prohibited from participating in any agreement with healthcare providers, network of providers, TPAs, or others who offer access to a network of providers, if that contract would, directly or indirectly, prevent the Plan from:

- Disclosing provider-specific cost or quality-of-care information or data, through a consumer engagement tool or other means, to referring providers, the plan sponsor, enrollees, or individuals eligible to become enrollees.
- Electronically accessing de-identified claims information.
- Sharing the above information with a business associate.

This seems to only apply to future contracts, but it is unknown how this will apply to existing contracts when being renewed or modified.

Mental Health Parity and Addiction Equity Act (MHPAEA) (effective February 10, 2021)
The MHPAEA prohibits plans that offer mental health and substance use disorder benefits to offer less favorable terms and conditions than the plans medical/surgical benefits offered.

Information About Direct and Indirect Compensation (effective December 27, 2021)
Requires disclosures of direct and indirect compensation brokers and consultants who receive over $1,000 during term of contract with a plan.

Reporting on Drug Prices (effective December 27, 2022 and June 1 each year thereafter)
Every group health plan and insurance issuer that offers group or individual health coverage must submit an informational report on pharmacy benefits and drug costs to the Secretary of Health and Human Services, Secretary of Labor, and Secretary of Treasury annually.

In addition to the CAA, the Departments of Labor, Treasury, and Health and Human Services (HHS) issued the final "Transparency in Coverage" regulations. The Transparency in Coverage final rule seeks to increase transparency of medical costs through the publishing of price information estimates. With the passing of the No Surprises Act, Transparency in Coverage, and the Transparency rules within the CAA, it is thought that patients wishing to receive medical care will have a better understanding of their medical costs upfront. This will help to alleviate any surprise medical billing and give the patient some insight into what their choices in medical care may cost them. For further information, please contact Neil Rolland, Trexin's Healthcare & Life Sciences Practice Lead, at neil.rolland@trexin.com.

References:

https://www.compliancedashboard.net/a-prohibition-on-gag-clauses/
https://www.truckerhuss.com/2021/01/an-overview-of-the-group-health-plan-provisions-of-the-consolidated-appropriations-act-and-the-final-transparency-in-coverage-regulations/
https://www.natlawreview.com/article/consolidated-appropriations-act-underscores-mental-health-parity-compliance
https://www.winston.com/en/benefits-blast/caa-benefits-alert-new-health-plan-reporting-on-pharmacy-benefits-and-drug-costs.html
https://www.healthaffairs.org/do/10.1377/hblog20201217.247010/full/
https://rules.house.gov/sites/democrats.rules.house.gov/files/BILLS-116HR133SA-RCP-116-68.pdf

This TIP was written by Trexin Analyst, McKenna Wiley. McKenna welcomes comments and discussion on this topic and can be reached at mkenna.wiley@trexin.com.